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Concept Paper: Model Comprehensive Program for
Treatment of Substance Abuse

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I. Introduction

This **concept paper** describes a new addiction treatment program for the Washington, DC metropolitan area, mandated by Public Law 102-321 - July 10, 1992.

In responding to the requirements of the legislation, two priorities have been addressed. The first is to create a model for the National Capital Area which will provide high-quality, comprehensive, cost-effective treatment for addiction to alcohol and other drugs for high-priority addicted people throughout the metropolitan area. The second priority is to create a new service delivery model that can be used by other communities in the United States to fund addiction treatment with scarce public funds.

In developing this concept paper, the service delivery mechanisms for drug and alcohol addiction treatment in the public and private sectors over the past 20 years have been reviewed, and the most desirable features of each have been combined to create a new approach to deliver the best possible addiction treatment.

II. General Background

A. Legislation

On July 10, 1992, Public Law 102-321 authorized the Secretary of Health and Human Services (HHS) to establish a demonstration program in the National Capital Area for a **"Model Comprehensive Program for Treatment of Substance Abuse"** (Public Law 102-321). (See Appendix A for the full text of the legislation.) The legislation requires (1) that all individuals who seek and would benefit **from treatment** should receive it; (2) employment education,

relapse prevention, and parental involvement; (3) accessible treatment location; (4) priority to intravenous drug users, pregnant women, the homeless, and residents of public housing; (5) child care to women seeking treatment; (6) outreach activities to promote treatment; (7) case management, including public health, mental health, and social services; (8) efficient public information, coordination, and administration of the treatment services; and (9) establishment of staff certification standards and quality programs.

Grant eligibility is accorded to general-purpose local government or other public or nonprofit private organizations within the national capital area. Matching funds of \$1 non-federal contributions to each \$2 of federal funds are required. Non-federal contributions may be monetary or in-kind services, equipment or facilities.

The Secretary of HHS will independently evaluate the effectiveness of the model treatment program. The extent to which high-quality, client-oriented, coordinated and accessible drug treatment is available across jurisdictional lines will determine its suitability as a model for other areas of the United States. The model treatment program will be evaluated for its ability to improve client retention, provide accessible services, retain quality staff, reduce relapse to drug use, and provide a full range of drug treatment and related health care and social services. Innovative methods for overcoming the resistance of community residents to establishing treatment facilities within the

communities will also be evaluated. Other evaluations may also be required.

B. National Capital Area

The national capital area (as described in the legislation) includes the 8 political jurisdictions in Washington metropolitan area of the District of Columbia, the counties of Arlington and Fairfax and the cities of Alexandria, Falls Church and Fairfax in Virginia; and the counties of Montgomery and Prince George's in Maryland. The metropolitan area encompasses 1480 square miles.

In 1990, the total population of the National Capital Area was **3,223,098**. The population of the District of Columbia was 606,900; Arlington County, 170,936; Fairfax County, 818,584; the City of Alexandria, 111,183; Falls Church, 9,578; City of Fairfax, 19,622; Montgomery County, 757,027; and Prince George's County, 729,268.

C. Current Treatment Providers

Current alcohol and drug abuse treatment programs in the national capital area include a large number of both public and private providers. Alcohol and drug abuse treatment programs are operated by city or county agencies, medical and psychiatric hospitals, and private non-profit and for-profit organizations. Each jurisdiction contains a substantial variety of alcohol and drug abuse treatment programs in each of these categories. These include, but are not limited to, medical and social detoxification facilities, short-term inpatient programs, residential treatment (therapeutic communities), day-treatment, halfway houses, outpatient **methadone maintenance and drug-free programs, and**

programs associated with the correctional system, including DWI, probation and parole programs focusing on addiction. Each jurisdiction does not necessarily include each type of treatment program. Currently, a few of the jurisdictions purchase specific services, for example, medical detoxification, from providers in neighboring jurisdictions.

III. Discussion of the Development Process

A. The Unique Mandate Provided by Public Law 102-321

The 1992 law establishing this project provides a unique foundation for the new demonstration substance abuse treatment program. The addiction treatment program must meet the needs of specific, defined high-risk clients suffering from serious addiction to alcohol and other drugs. It must serve the entire metropolitan area. It must seek out the best addiction care available, and improve the over-all quality of this care. The new program must be built at a total initial cost to the federal government of not more than about \$3 million annually. The recipient of the contract funds must be an organization representing **the** local jurisdictions in **the** Washingtonmetropolitan area. The treatment program must strengthen, not supplant, the best providers of addiction services in the area, as well as stimulate the development of additional services to underserved addicted populations. To succeed, the new program must receive wide support from the federal government agencies dealing with addiction treatment, the various local governments, and the major

providers of alcohol and drug addiction treatment within the metropolitan Washington, DC area.

B. Project Organization and Advisors

In January, 1993, the Center for Substance Abuse Treatment (CSAT) awarded a small **90-day** contract to the Institute for Behavior and Health, Inc. (IBH) to facilitate the development of the new addiction treatment project, leading to the publication of an RFA by the Secretary of HHS.

In fulfilling the terms of the contract, IBH established contacts with a wide range of the leading public and private providers of **addiction treatment** in the metropolitan area, with **the** Council of Governments (COG) a private, nonprofit organization representing the region's local governments, and with COG's Drug Intervention, Treatment and Rehabilitation Committee, comprised of the substance abuse administrators in the COG member jurisdictions.

IBH established a local advisory committee and a national advisory board to assist in the development of the plan. (See Appendices B and C for the names of these individuals.) Many of the members of the local advisory committee were leaders in the development of addiction treatment service delivery who have remained leaders at both the local and national levels for a quarter of a century. They joined in this planning process because they were challenged by the importance of this task and excited by the prospect of helping to create a new national model for drug and alcohol addiction treatment. The members of the national advisory **group were selected for their leadership and involvement with**

current innovative, state-of-the art drug treatment programs and practices.

c. Alternative Solutions to the Problem

IBH **and the** local advisory committee considered three distinct solutions to the problem posed by the legislation:

1. Block Grant to Augment Existing Programs. The first approach considered was a modified and targeted regional block grant approach in which each of the 8 local jurisdictions would receive a portion of the federal funds available through this project to augment addiction treatment in their communities. This new funding would be administered by a central contracting agency in such a way that the funding would be proportional to population and only would be used to enhance available treatment services by treating more people or by improving existing treatment services. The advantages of this approach are its simplicity and the ease and low cost with which it could be administered. On the other hand, there are obvious disadvantages to this approach. It does not create a new model program, and it is be difficult to administer the program in such a way as to improve the quality or quantity of care provided for addicted people provided in **the** metropolitan area since there are no obvious parameters by which these characteristics could be assessed reliably and objectively.

2. New Exemplary Addiction Treatment Program. The second approach considered was the development of one or several small model addiction treatment programs. This approach would create clearly identifiable new model addiction treatment programs

which might be able to provide uniquely high quality addiction treatment services. However, the legislation requires that the needs of high priority clients throughout the metropolitan area be met by the new program, necessitating geographically diverse treatment sites.

Several drawbacks are immediately apparent to this approach. Three million dollars a year spread over the entire metropolitan area would fund treatment for relatively few people. Transportation constraints would limit the services to a tiny segment of the region's population of addicts. Additionally, starting entirely new addiction treatment programs would be extremely difficult, taking a year or more from initial funding to treating the first client. Moreover, this approach is complicated to administer and does not to enhance the quality of the current drug and alcohol addiction services in the metropolitan area. In fact, this approach creates new programs competing with those now in existence in the metropolitan area.

A modification to this approach would better permit it to fit into existing treatment: a central agency would contract with several existing treatment programs to enhance or extend their services to additional clients by purchasing additional capacity as measured in quality or quantity of services or both. This modification supports a few selected addiction treatment programs, but it does not create a model substance abuse treatment program and it would not benefit the vast majority of the addiction treatment programs which currently provide services to addicts in

the community. Additionally, it would be difficult to rationalize fairly which current treatment programs would receive these added funds. Decisions would have to be made in ways which at the very least would not likely to appear to be fair or equitable.

3. Case Management Approach. The third approach considered was the case management approach in which a central agency would act as the sponsor of selected high priority addicted people in the area and, using clinical case management techniques, would manage their cases **throughout the** treatment continuum. In this model, the current treatment programs would provide both intake and treatment services. The central case management agency would function much as an employee assistance program (EAP) or managed care provider or an insurance company's utilization review manager to find the best treatment in the metropolitan area and to contain the cost of care for each client.

The first priority, quality care measured objectively by results, would be achieved by four quantifiable standards traditional for addiction treatment: retention in treatment; freedom from the use of alcohol and other drugs nonmedically as measured by urine, hair and breath tests; employment or other appropriate role performance in the community; and freedom from arrest on criminal charges. The second priority for the new program - cost containment - would stretch scarce public funds for addiction treatment as far as possible, while enhancing the services provided by existing area addiction treatment programs.

This approach would permit the identification of the providers of addiction treatment in the Washington metropolitan area with the best results and the lowest costs. It would permit the use of the full resources of all of the addiction treatment and other health and social service providers in an integrated, managed system dedicated to meeting the individual client's high priority needs. It would also permit a fair system of priorities for client admission and treatment selection based on measurable factors such as addiction severity, effectiveness of treatment and costs of care.

D. Selection of the Model

After careful consideration of each of these models, and some creative ways they could be combined, the case management approach was selected as the most likely to fulfill the promise of this historic initiative in the nation's capital. The remainder of this concept paper focuses on this model. The model holds the promise of meeting all of the objectives set out by the legislation, including the potential of being a national model in both the public and private sectors, of being a catalyst to enhance the quality of care delivered by current treatment providers in the community, and a way of identifying unmet treatment needs in the community.

IV. The Model Treatment Program (MTP)

The Model Treatment Program (MTP), will serve 8 political jurisdictions in the metropolitan Washington, DC area. A central administrative office will provide overall coordination and fiscal

management of the program, clinical outcome-driven case management, on-going training for all treatment providers in the metropolitan Washington, DC area, and follow-up assessments. Clients will enter treatment at widely dispersed existent public and private non-profit intake facilities throughout the region. The central administrative office will identify, using treatment outcome data, those programs that are providing high quality, reasonable cost treatment appropriate to each client. Providers who fail to meet this standard will receive peer-based technical assistance to enhance the quality of service delivery so that they can qualify for MTP clients.

The MTP is designed to enable priority addicts (those from the criminal justice system, pregnant addicts and addicted mothers, the homeless, residents of publicly assisted housing, and IV drug users) with a potential for success in addiction treatment to be placed in the most appropriate alcohol or drug treatment program in the metropolitan Washington, DC area.

Potential clients may self-refer to the MTP or be referred by the criminal justice system (CJS), family services, or other referral agencies. Centralized, accessible, existent intake centers in each jurisdiction will provide assessment of each client, using an MTP assessment instrument.

The intake counselor will confer with an MTP clinical case manager at the central administrative office. If the individual client meets eligibility criteria and treatment capacity exists within the MTP system, the client, the intake counselor, and the

MTP case manager will decide on the most appropriate treatment program based on the specific needs assessment, program availability and accessibility.

Once the client enters treatment, the case manager will follow the individual's progress on a regular basis. Available treatment resources will follow a continuum of care based on the client's needs. Additional services required by specific clients will be managed by the MTP case manager.

After the specified treatment program is completed, or the client **leaves treatment** before completion, follow-up assessments on each client will be conducted at 6 months, 1 year, and 3 years. The MTP model is designed to provide useful evaluation data to determine costs and benefits of various addiction treatments for a wide variety of addiction treatments for a diverse client population. The follow-up function will be carried out under a separate contract related to the over-all MTP evaluation.

MTP treatment providers will be encouraged to make full use of the 12-step programs such as Alcoholics Anonymous, Narcotics Anonymous, and Al-Anon to enhance the quality of care and the outcome results. Clients will be encouraged to participate in these mutual-aid programs of recovery after treatment is complete. However, the MTP is mindful of the unsettled state of research with respect to the role of these mutual-aid programs in long term recovery, so one of the major features of the MTP outcome study will be the correlation between 12-step program participation and outcome results. Two **other critical features of the MTP study**

design are first that use and non-use of alcohol and other drugs will be systematically and objectively assessed by regular testing in treatment and during the three-year follow-up after treatment, and second that the outcome assessment will focus on four key factors: program retention (or duration of treatment), use of alcohol and other drugs, employment or other productive activities in the community, and criminality. Each of these factors will be regularly and objectively assessed for the MTP clients. In addition, the MTP evaluation system will capture major program services delivered to each client on a weekly basis. It will be possible to correlate outcomes with specific levels and types of services provided to clients within various treatment categories and programs. In this way addiction treatment will not be treated as a **"black box"** measuring only outcome, but the specific services delivered in each program will be correlated both with costs of care and outcomes, both favorable and unfavorable, of treatment. This will permit identification of specific services which are correlated with more favorable outcomes.

A. Central Administrative Function

The central administrative office of the MTP will serve both as the agency contracting with the federal government, and also negotiate contractual relationships with service providers and others, as appropriate. This office will be responsible for all fiscal management of the project, including tracking the matching dollars as required under the provision of the authorizing legislation. The office also will provide education and training

to treatment providers in the metropolitan Washington, DC community, as well as information and technical assistance to other communities within the United States that are interested in visiting the office to learn more about the model program.

Other functions of the central administrative office will be

1. Case/Outcomes Management of Clients

The central administrative office will be responsible for the active case management of clients (in contrast to the utilization review characteristic of many of today's managed care providers) including assignment (and re-assignment to a second treatment program, if necessary) of clients to treatment facilities, and monitoring treatment progress on a weekly basis. This function may be implemented by staff of the primary contractor or may be sub-contracted in whole or in part. It is expected that each case manager will supervise approximately 75 clients. Each case manager will specialize in managing a group of the targeted client populations and will be responsible for making regular quality assurance visits to specific treatment sites.

Treatment resources from the MTP will be expended only for addiction treatment, but the treatment programs and the MTP case managers will access related public and private services (such as medical treatment for non-substance abuse problems or vocational rehabilitation services) to maximize the care of each client.

The MTP treatment capacity will be allocated to the 8 jurisdictions in **proportion** to their populations as reported in **the** 1990 census. when the treatment allocation for a particular

jurisdiction is fully utilized, prospective clients from that jurisdiction will continue to be accepted if there is unused MTP capacity within another jurisdiction's allocation (essentially, borrowing slots). The full **MTP** resources are to be utilized at all times, though when slots are borrowed, the loaning jurisdiction then has priority within the MTP when new need arise. Priority will be given to clients seeking to participate in the MTP base on the seriousness of their need, combined with their ability to benefit from addiction treatment at a reasonable cost. Sensitive priority judgements will be made by the MTP staff, in consultation with the MTP Advisory Board (see section H). The standard used both by MTP staff and the Advisory Board will be the best interests of the addicts seeking treatment and the communities being served. The MTP must be aware **that the** demand for addiction services vastly exceeds the available funding, so that a fair, practical and flexible system of priorities needs to be maintained.

2. Management Information System (MIS) Requirements

A responsive, sophisticated management information systems capability will be the key to integrating the MTP. The MIS will provide remote site case management, evaluation of treatment facilities, follow-up data, and accounting functions. The central office will require a computerized MIS system to support the following:

- a. **Case** management: demographic and intake data and weekly treatment activity including referrals, the client's **Clinical manager in the treatment process, other agency**

(probation, parole) jurisdictional responsibility and name of supervisor, and the outcome of treatment;

- b. Treatment availability: current information on treatment centers by geographic location, type of treatment available, number of slots available, type of client accepted, cost of treatment, and length of treatment.
- c. Financial management: contractual grants management capability for entire project and for project components including total dollars allocated per client, source of match dollars from treatment providers, cost of treatment services to-date, and aggregate match dollars to-date.

It is expected that such a system will use a currently available software package, modified, if necessary, **for the** project requirements. The software selected should not be held solely by one vendor, but should be generally available and easily programmed and maintained by a variety of computer support organizations. Prior to a decision regarding purchase, modification, and implementation of such a system, a detailed hardware and software systems analysis should be undertaken that fully describes the system requirements.

The feasibility of remote site computerized data entry and electronic transfer of information should be explored at the systems design stage of development to support the treatment facilities that have the capability. For those sites that do not have such capability, MTP computer forms should be developed,

preferably to be read into the central administrative system by an optical character scanner.

B. The Client Population

1. Selection of Clients to be Served

The legislation specifies certain populations at high risk of drug abuse. Within the metropolitan Washington, DC area, the client pool in any given category is larger than the available treatment slots. In order to derive the highest treatment benefit for available dollars, priority will be given to clients referred from and monitored by either the local criminal justice system or by a local child protective services agency. Working jointly with probation or parole officers, or with case workers from other agencies, the MTP case manager and the treatment staff will be able to provide continuity of care and supervision. Within the pool of targeted high-risk substance abusers, those with the highest predictors for successful treatment outcome will be selected.

Clients seeking admission to the MTP will be evaluated at designated intake facilities using MTP procedures that include a patient profile and an assessment of the severity of the patient's problems.

2. Total Number of Clients in Year One

It is expected that 30 clients per week will be enrolled, and that the total number of clients seen in the MTP at any one time will total 750 clients. Clients will be considered to be in active treatment only if seen at least once in the prior month with a **urine test to verify drug-free status.**

c. Selection of Providers

Within each of the 8 jurisdictions, it is expected that most current providers of addiction treatment services will want to participate in the MTP. As an initial project stage, an announcement of the project's design and terms of participation will be distributed to all eligible public and private treatment providers within the metropolitan Washington, DC area, followed by a technical briefing describing the project requirements and objectives for all interested agencies and organizations. All treatment organizations from each jurisdiction will be accepted for the initial project if they meet the requirements for addiction treatment providers within their specific jurisdiction, and following a site visit by an MTP case manager. Selection parameters will include the range of treatment services offered, type of clients served, cost, client outcome data, and willingness to cooperate with MTP systems and objectives. Preference will be given to providers currently providing services to clients in the designated high-risk populations, and to providers who will tailor programs to respond the needs of these populations.

Should MTP funds be expanded following the initial pilot year, additional treatment capacity will be added. As a part of the central administrative function, treatment providers will receive ratings for particular types of clients based on objective treatment outcome and cost measures. Public recognition will be given to highly rated programs, while technical assistance will be provided to lower performance providers by the central office using

peer counseling from successful programs in response to problems identified by the MTP system.

The MTP will use not only publicly funded and private-nonprofits, as specified in the legislation, but over time will seek to include private for-profit providers of addiction treatment in the hopes that this added competition will benefit all. The objective of the MTP is to create a functioning market for the addiction community in which those programs that can provide consistent and cost-effective services will provide leadership for the entire addiction treatment community. The standards will be based on objectively measured results.

When gaps are identified in the current addiction treatment provider network in the metropolitan area, the MTP will work with current and potential providers of services to fill them. This will not only serve the interest of the MTP clients, but also the interests of all the addicted people in the metropolitan Washington, DC area. The MTP process permits the identification of specific gaps and provides an opportunity to fill them.

D. Intake

Clients may be referred to the MTP from the criminal justice system, child protective services, or other organization, including treatment providers throughout the metropolitan Washington, DC area. In addition, clients may present themselves as candidates at any of the designated intake facilities in each of the jurisdictions participating in the MTP. Results of a preliminary screening instrument conducted with the client will provide a

clinical case manager at the central administrative office sufficient information to authorize a complete MTP evaluation, or to reject the application.

The intake will be conducted using MPT intake instruments. A revised form of the Clinical Intake Assessment Instrument, or other widely used assessment instrument, be used for this purpose. The MTP will give preference to intake, treatment process, and follow-up instruments that are used nationally and are easy to use. They must be brief, and easily modified for the purpose of the MTP. It is essential that the data collection process will not inflate the cost of treatment services or burden the intake process or treatment of clients.

Once the intake is completed, the intake counselor will telephone the case manager in the central administrative case management office and present the intake information in summary form. If the individual meets entry criteria and a treatment slot is available the client will be accepted into the MTP and assigned to a program, or the applicant will be rejected. A waiting list will not be kept. The MTP will operate on the principle of treatment-on-demand, to the extent that treatment capacity exists. The outcome research design may match MTP clients with those not accepted to determine if there are differences in outcome. Because addiction treatment is prolonged and visits to treatment facilities are frequent, geographic proximity of the treatment provider to the client's home and work will be an important factor in treatment program assignment.

E. Treatment

Multimodality treatment will be provided by existing addiction treatment programs throughout **the** metropolitan region. The central administrative office will develop and maintain a database of all participating treatment programs. Treatment programs will be assessed for eligibility by MTP case managers using criteria such as duration of operation, staff turnover, number of months at existing location, drug testing system, client retention, frequency of client contacts with the program, and program commitment to long-term treatment success. Qualifying programs will submit **type**, duration and cost of treatment information to the central administrative office and will cooperate with the objectives and procedures of the MTP.

Mobile units are specifically addressed in the legislation establishing the MTP. At present, the City of Baltimore, Maryland is operating two such mobile units funded under a grant from the National Institute on Drug Abuse (NIDA). Mobile units appear to be most successful when used within a relatively small geographic area. Moreover, they are costly to equip and difficult to maintain. In view of the fact that the full funding specified in the legislation for the model **treatment** program in the metropolitan Washington, DC area was not authorized in FY 1993, it is recommended that further study be made of the experience with mobile units in Baltimore prior to expenditures on such units for the MTP.

The MTP case manager assigned at the time of initial intake to a particular client will determine the specific treatment program to which the client will be assigned. Client preferences will be considered as one important factor in determining program assignment. If an MTP clients fail in the treatment program to which they are initially assigned they can be assigned to an alternative addiction treatment program by the MTP case manager if the second assignment appears to be in the client's and the MTP's interests. If a client fails at the second addiction treatment program, or refuses an assignment made by the MTP case manager to a second program, then the client will not be accepted back into the MTP for at least one year after the termination of treatment. This policy will reenforce the importance of staying in treatment and ensure that scarce MPT resources are used for the clients most likely to benefit from them, rather than being used excessively by clients who do not appear to be benefitting from the MTP care.

MTP case managers will meet clients face-to-face at least once within the first month of treatment. Clients will be permitted to contact their MTP case mangers directly, and the MTP case managers will review each client's progress with the client's supervisor from the treatment program on the telephone or in person at least once a month. The MTP will develop a data collection system that will be used for all MTP clients, regardless of which treatment programs they enter. These MTP data collection instruments will be used in addition to whatever data is currently collected in each participating treatment program.

F. Training and Technical Assistance

Programs that wish to participate in the MTP, but that do not appear to have met the qualifying criteria, may appeal that judgement to the MTP Advisory Board (see section G.) They may also request technical assistance from the MTP central administrative office for program improvement or enhancement or for staff training.

Programs that are judged to be performing poorly as compared to other programs offering similar services to similar clients within the metropolitan Washington, DC area will be given fewer or no MTP clients while they are offered peer technical assistance during a probationary period. Following this probationary period, they will again be given clients to see if their performance has improved. The MTP will hold monthly educational and training meetings for all of the metropolitan Washington, DC addiction treatment community. These meetings will feature presentations by national and local leaders in the prevention and treatment of addiction. The MTP will conduct frequent training sessions on an ongoing basis for all providers of addiction services in the metropolitan area, whether or not they are participating in the MTP.

G. Follow-up

Follow-up client assessments will be made at 6 months, one year and 3 years after the termination of treatment. Follow-up will be conducted by the MTP case manager in a face-to-face meeting and will include information regarding urine and hair test results,

participation in 12-step meetings, and an assessment of the client's adjustment in the community. It is expected that this function will be provided by an independent contractor as part of the **MTP's** overall evaluation funded separately by the Center for Substance Abuse Treatment (CSAT).

H. Advisory Board

The MTP Advisory Board will be responsible for deciding placement priorities and determining when programs have succeeded or failed in determining future MTP client assignments. This Board will be made up of 6-8 community leaders knowledgeable about addiction treatment and respected by the local addiction treatment community.

I. The **Match**

An in-kind match of one local dollar for every two federal dollars must be documented. This is required for central administrative activities as well as provision of treatment services. However, a rigid adherence to the match concept would have a negative effect on the MTP program objective, as it would discourage the provider programs from an honest statement of their costs and would encourage them to inflate their normal costs of services. The intent of the legislation is to enhance the addiction treatment services provided in the area, and not to replace other funding. This model achieves the spirit of that objective. Each component of the MTP must sign a formal statement for the MTP central office indicating how the match requirements will be met.

J. Payments to Service Providers

Each program receiving MTP funding must sign an agreement that all of the MTP dollars will be used either to enhance services of current clients or to provide services to additional clients. The MTP will negotiate for services with the expectation that the public interest will be best served by a well-functioning intelligent market system of competition to provide high-quality, managed cost care.

The MTP will negotiate a daily rate for treatment services with each prospective treatment provider. It is anticipated that the daily rate will be the rate now paid to each program from public or private funds for similar services. It is not expected that the MTP will receive a discounted or subsidized rate. A reduced rate for the MTP would have the perverse effect of requiring other clients in treatment at these programs to subsidize MTP care, thus making those services more expensive and/or less accessible. The MTP is designed to enhance and extend addiction treatment to all in the metropolitan area.

The MTP will identify the daily costs for the full range of services provided to alcohol and drug addicts by participating MTP treatment providers and will monitor these costs. The MTP will pay the participating treatment programs their daily rate, as negotiated in advance, for the MTP clients in treatment for the duration of their care. Payments will stop as of the last day clients received services on-site at the treatment program. For all treatment providers a visit frequency of less than twice a week

must be approved by the MTP case manager. Under no circumstances will client visits of less than one time per month be accepted for MTP payments. It is expected, for purposes of initial planning that the average cost of an MTP case will be \$4,000 per client year of care, and that 90% of the care will be on an outpatient basis. When detoxification services are required, non-medical detoxification will be the priority assignment category, in order to control costs.

Over time, efforts will be made by the MTP to bring down the costs paid by the MTP for services, as efforts are made by the MTP and the providers to raise the effectiveness of services as measured objectively by specific outcome results. Providers at the high end of the cost scales will be made aware of this fact, and an effort will be made to understand why their costs are higher than at programs offering similar services. If the higher costs are justified by superior outcome results, then the MTP may encourage more costly and better treatments at other addiction treatment programs in the MTP system. If, on the other hand, the added costs are not reflected in superior results, then efforts will be made by the MTP to lower the elevated costs. The efforts both to improve quality and to lower costs will be made by the MTP with full respect for different types of addicts and for their varied needs. Respect will be shown for the varied circumstances of addiction service providers. The MTP's goals are not to punish poor programs, but to reward good programs and to enhance and improve the services and lower the cost of all providers in the

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metropolitan Washington, DC area. The MTP system provides for the first time, a system for improving the quality and cost performance of all of the addiction treatment services in the metropolitan Washington, DC area.

All of the dollars that each of the treatment providers receives from the MTP must be used to enhance current services or to extend services to additional clients. None of it may be used to replace other funding received by the treatment provider. The MTP will develop formal contractual relationships with each participating treatment provider to ensure that these terms are met. At the end of each year each participating treatment program must give the MTP a report stating how all of the money used from the MTP was used. The MTP funding will be subject to formal audit procedures by the MTP to ensure compliance.

xc. cost

The MTP will be phased in to full capacity depending on the availability of funds in FY 1993. See Figure 1 for a proposed fully operational year one estimate of costs expected to be covered by federal funds.

The MTP central administrative office will be expensive, especially during the initial start-up period, when it will consume approximately 20% of total federal funding. Over time the MTP will recover the costs in terms of higher quality of care and managed cost containment not only for the MTP clients, but for all addicts being treated in the metropolitan area. The MTP can become a powerful force for good in the entire community.

Once it is established, the MTP will be administered without great administrative demands. The major challenge is to establish the MTP so that the goals and the techniques are clearly defined and the systems to achieve these goals are functioning smoothly.

Figure 1
Model Treatment Program
Year One Budget (Preliminary)

Central Administrative Office

Personnel

Administrator	\$ 45,000	
Case Managers* (8 x \$35,000)	280,000	
Trainer	40,000	
Financial Manager/Analyst	40,000	
Bookkeeper	20,000	
Computer Data Entry (2 x \$18,000)	<u>36,000</u>	
		\$ 461,000
Overhead @ 25%	<u>116,000</u>	
Subtotal**		\$ 577,000

Payment to Treatment Providers

\$4000/patient/year x 605 patients	\$2,423,000	
Total		\$3,000,000

* Case load of approximately 75 clients each

** Central Office Costs = 19% of the total budget

Note : Fractional numbers have been rounded to the nearest thousand. This budget is for discussion purposes only.

Appendix A
Legislation

Appendix B
Advisory Committee

Chairperson:

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Members of the Committee:

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Appendix C

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